NEBRASKA DEPARTMENT OF HEALTH AND HUMAN SERVICES

EHR MEDICAID INCENTIVE PROGRAM FOR ELIGIBLE HOSPITALS

02/2013

BACKGROUND AND OVERVIEW

Medicaid Electronic Health Record (EHR) Incentive Payment Program Background

- Section 4201 of the American Recovery and Reinvestment Act of 2009 (ARRA) authorized funding for Medicaid programs to run incentive payment programs for the adoption and meaningful use of health information technology (HIT).

- Planning, implementation, and operation of the Electronic Health Record (EHR) incentive program is funded 90% by the federal government, 10% by state general funds.

Medicaid EHR Incentive Payment Program Background

- Incentive payments to providers who participate in the program will be funded 100% by the federal government.
- The final rule governing the EHR incentive program was published to the Federal Register July 28, 2010, with a clarifying amendment added December 28, 2010.

http://www.regulations.gov/#!documentDetail;D=CMS_FRDOC_0001-0520;oldLink=false

Medicaid EHR Incentive Program Overview

- The purpose of the incentive program is to encourage eligible Medicaid providers to adopt and subsequently meaningfully use certified EHR technology.

- Incentive payments are NOT intended to cover all of the costs involved in EHR adoption and implementation, and practice re-organization.

- The incentive payment is issued after a provider demonstrates program compliance.

ELIGIBILITY

Eligible Hospitals

- Acute Care Hospitals (including Critical Access) which have a CCN that ends in 0001-0879 or 1300-1399. Must meet a Medicaid patient volume of 10% in any 90-day or three-month period within 12 months preceding the date of attestation
- Children's Hospitals which have a CCN that ends in 3300-3399. Medicaid patient volume is not needed for children's hospitals.

Key Points:

- Be in the list of eligible hospitals
- Meet the 10% minimum Medicaid patient volume in a 90-day or three-month period in the 12 months preceding the date the enrollment is received
- Adopt, Implement or Upgrade to a certified EHR System or be demonstrating Meaningful Use

PATIENT VOLUME

Patient Volume Calculation

Total Medicaid patient encounters in any consecutive 90-day or three-month period in the 12 months preceding attestation

_____ X 100

Total patient encounters in the same period

PATIENT VOLUME

- Count inpatient discharges
- Count emergency room visits where the revenue code is 450-459. If the same patient was treated in the emergency room more than once on a given day, only count as one encounter.
- Only Medicaid payments paid through funding with Title XIX or Title XXI of the Social Security Act can be included in the encounters. This includes the Kids Connection program (also known as CHIP). State-only funded programs, Federal grant-funded programs, and certain other programs still cannot be included. Since Nebraska pays all of these under the Medicaid program and there is no distinction of the funding source on the Medicaid card, DHHS will need to help separate these.

PATIENT VOLUME (CONTINUED)

- Include managed care encounters
- Include nursery bed days, psychiatric care, regular inpatient care, etc.

REGISTRATION AND ENROLLMENT

REGISTRATION

The first step in the process is to register with CMS. There is a CMS user guide to help you with the registration process. This is the link for registration with CMS: https://www.cms.gov/EHRIncentivePrograms/20_RegistrationandAttestation.asp#TopOfPage

ENROLLMENT

After registering with CMS, wait 24 hours for the information to be electronically sent to Nebraska DHHS from CMS then complete the enrollment form with DHHS. The enrollment form can be obtained from our website http://dhhs.ne.gov/medicaid/Pages/med_ehr.aspx.

Registration is at the Federal (CMS) level, Enrollment is at the State Medicaid (DHHS) level

Department of Health & Human Services
DHHS
NEBRASKA

Division of Medicaid and Long-Term Care

Eligible Hospital (EH) EHR Incentive Program Enrollment and Attestation

Contact Information for all inquiries and responses

First Name | M.I. | Last Name | Suffix | Job Title

Phone number (include area code) | E-mail address

Provider Information

Name of Hospital | NPI (National Provider Identifier) Number | Medicaid Number

CCN Number | Provider Type (please select one)

☐ Acute Care Hospital (including Critical Access Hospital) ☐ Children's Hospital

Patient Volume Information

What is the continuous 90 day period for which you are reporting patient volume?

From: | To:

Medicaid Patient Encounters

Total Medicaid patient encounters during the reporting period | Total patient encounters during the reporting period

Were any of the above Medicaid patient encounters provided to an individual(s) covered by a Medicaid program other than Nebraska? ○ Yes ○ No

If yes, which states | Percentage of patient volume in the other states

Please indicate the stage of your EHR system.

☐ Adopted ☐ Implemented ☐ Upgraded ☐ Demonstrating Meaningful Use

Provide the ONC Certification Number for your EHR system

Medicare Cost Report Information

Please complete the right column in the table below.

Data Element	If data is drawn from CMS 2552-96:	If data is drawn from CMS 2552-10:	Reported Data Please complete
Total Discharges - Fiscal Year 1*	Worksheet S-3, Part I, Column 15, Line 12	Worksheet S-3, Part I, Column 15, Line 14	
Total Discharges - Fiscal Year 2	Worksheet S-3, Part I, Column 15, Line 12	Worksheet S-3, Part I, Column 15, Line 14	
Total Discharges - Fiscal Year 3	Worksheet S-3, Part I, Column 15, Line 12	Worksheet S-3, Part I, Column 15, Line 14	
Total Discharges - Fiscal Year 4	Worksheet S-3, Part I, Column 15, Line 12	Worksheet S-3, Part I, Column 15, Line 14	
Total Medicaid Days	Worksheet S-3, Part I, Column 5, Lines 1, 6-10 (and validated against MMIS data)	Worksheet S-3, Part I, Column 7, Lines 1, 8-12 (and validated against MMIS data)	
Medicaid HMO Days	Worksheet S-3, Part I, Column 5, Line 2	Worksheet S-3, Part I, Column 7, Line 2	
Total Hospital Days	Worksheet S-3, Part I, Column 6, Lines 1, 2, 6-10	Worksheet S-3, Part I, Column 8, Lines 1, 2, 8-12	
Total Charity Charges	Worksheet S-10, Line 30	Worksheet S-10, Line 20	
Total Hospital Charges	Worksheet C, Part I, Column 8, Line 101	Worksheet C, Part I, Column 8, Line 200	

Terms of Attestation and Agreement

This Agreement between the Nebraska Department of Health and Human Services, Division of Medicaid & Long-Term Care (hereinafter the Department) and the approved service provider governs the provision of the service(s) indicated in this Agreement as defined in the electronic health records final rule issued by the Centers for Medicare and Medicaid Services (CMS–0033–F), the EHR Incentive Program Manual, Nebraska Administrative Code (NAC) Titles 465 and 471, Appropriate checklist(s) marked 'Provider Addendum (name of service)" and other appropriate additions to the agreement marked "Attachment (A, B, or C)" for services is/are attached and by this reference are made part of this agreement. A complete Agreement is effective, upon acceptance by the Department, by formal notification to a provider that the Agreement has been accepted.

As a provider participating in the Electronic Health Record Incentive Program for the Medicaid & Long-Term Care programs specified in this agreement, the Provider assures:

1. Full compliance with the regulations and applicable policies and procedures of the Nebraska Department of Health and Human Services in the administration of program services. http://www.dhhs.ne.gov/Medicaid/ and http://dhhs.ne.gov/Pages/reg_t471.aspx;
2. Full compliance with all applicable Federal statutory and regulatory law;
3. Full compliance with the State's audit process;
4. Full compliance with requirement found at 42 CFR 455.432 specifying that the provider agrees to permit CMS, its agents, its designated contractors, or the State Medicaid agency to conduct unannounced on-site inspections of any and all provider locations;
5. Full compliance with requirement found at 42 CFR 455.434 specifying that the provider consents to criminal background checks including fingerprinting when required to do so under State law or by level of screening based on risk of fraud, waste, or abuse as determined for that category of provider;
6. That the payment determined in accordance with the policies of the Nebraska Department of Health and Human Services will be the full and complete payment for the satisfaction of program requirements, and the amount paid will be accepted as payment in full and that no additional payment will be claimed.
7. That all goods and services for which payment will be claimed will be provided in compliance with the Civil Rights Act of 1964, and Section 504 of the Rehabilitation Act of 1973, and the Age Discrimination Act of 1975 (45 CFR, Parts 80, 84, and 90);
8. That service records will be retained as are necessary to fully disclose satisfaction of program requirements and the extent of the services provided to support and document all claims, for a minimum period of six years as required under HIPPA Section 164.530(j); The State can request supporting documentation.
9. It will allow federal, state, or local offices responsible for program administration or audit to review service records, in accordance with 45 CFR 74.20-74.24; and 42 CFR 431.107. Inspections, reviews, and audits may be conducted on site.
10. Provider understands that provider enrollment does not constitute employment by the State of Nebraska or guarantee referrals;
11. This agreement will not be transferred to any other person or entity;
12. Provider understands that any payment is made with federal funds and is contingent upon availability of those funds and federal requirements for disbursement;
13. That all information will be disclosed to Nebraska Department of Health and Human Services as required by policies of the Department;
14. Understanding that any false claims (including claims submitted electronically), statements, documents or concealment of material fact may be prosecuted under applicable State or Federal laws (42 CFR 455.18); and any incentive payments paid to the EP or hospital later found to have been made based on fraudulent or inaccurate information or attestation may be recouped by the State
15. The EHR incentive payments will be treated like all other income and are subject to Federal and State laws regarding income tax, wage garnishment and debt recoupment.
16. This form and any required addenda, and/or attachments must be completed and submitted prior to a request for payment being considered complete.
17. By signing this Agreement, the provider is agreeing to be bound by the appeals process set forth in Nebraska's Regulations

I have read and understand the terms of this agreement and attestation. I attest that the foregoing information is true, accurate and complete. I understand that Medicaid EHR Incentive payments submitted under this provider number will be from Federal funds and that any falsification or concealment of a material fact may be prosecuted under Federal and State laws.

Printed Name of Provider/Authorized Official Completing this Form	Job Title

Signature

Date

PAYMENTS

The payments for EHs are based on the Medicare Cost Reports. The hospital base year is the most recent 12 months that data is available.

	A	B	C	D
1	Please enter the the following information:			
2				
3	Hospital Name:			
4	CMS Certification Number #			
5	Base Hospital Fiscal Year			
6	Description	Medicare Cost Report 2552-10 Location	Medicare Cost Report 2552-96 Location	Entered Data
7	Total Discharges - Fiscal Year -3	Worksheet S-3, Part I, Column 15, Line 14	Worksheet S-3, Part I, Column 15, Line 12	
8	Total Discharges - Fiscal Year -2	Worksheet S-3, Part I, Column 15, Line 14	Worksheet S-3, Part I, Column 15, Line 12	
9	Total Discharges - Fiscal Year -1	Worksheet S-3, Part I, Column 15, Line 14	Worksheet S-3, Part I, Column 15, Line 12	
10	Total Discharges - Fiscal Year	Worksheet S-3, Part I, Column 15, Line 14	Worksheet S-3, Part I, Column 15, Line 12	

Total Charity Charges needs to be calculated from the amount of uncompensated charges minus the bad debt.

From Cost Report			
Total Medicaid Days	Worksheet S-3, Part I, Column 7, Line 1, Lines 8-12	Worksheet S-3, Part I, Column 5, Lines 1, 6-10	
Medicaid HMO Days	Worksheet S-3, Part I, Column 7, Line 2	Worksheet S-3, Part I, Column 5, Line 2	
Total Hospital Days	Worksheet S-3 Part 1, Column 8, Line 1, 2, Lines 8 - 12	Worksheet S-3, Part I, Column 6, Lines 1, 2, 6-10	
Total Charity Charges	Worksheet S-10, Column 3, Line 20	Worksheet S-10, Line 30	
Total Hospital Charges	Worksheet C Part 1, Column 8, Line 200	Worksheet C, Part I, Column 8, Line 101	

- USE THE PAYMENT CALCULATION TOOL ON OUR WEBSITE TO ESTIMATE THE AMOUNT OF YOUR PAYMENT

DOCUMENTS TO ACCOMPANY ENROLLMENT

- System generated report from the software system from which the patient volume calculations were made
- Proof of A/I/U (signed purchase order or signed EHR vendor contract, contract with REC or other entity with whom implementation exercises are planned, documented implementation work plan and EHR contractual agreement. This is not needed for dually-eligible hospitals if they have already completed their MU attestation with Medicare.
- Break down of the uncompensated care (amount that is charity care and amount that is bad debt)